Kansas Department on Aging

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		B089087	B. WING		12/2	3/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AUTUMN	HOME PLUS 2	720 NW WA TOPEKA, K	LNUT LANE			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	, -	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETE DATE
S 000	INITIAL COMMENTS		S 000			
		s are the result of an Initial named Home Plus Facility in 2/23/14.				
S5085 SS=D	26-42-201 (c) Function Reassessment	nal Capacity Screen	S5085			
	determine each reside according to the follow (1) At least once eve (2) following any sign as defined in K.A.R. 2	ry 365 days; nificant change in condition 26-39-100; and if the resident receives				
	This REQUIREMENT by: KAR 26-42-201(c)	is not met as evidenced				
	three Residents. Base interview, for one of the Operator failed to ens	al capacity screen (FCS) at				
	Findings included:					
	facility 01/01/14 with of Hypertension, Dyslipic kidney disease Stage behaviors. The record 11/05/13, identified as medical record lacked	evealed #187 admitted to diagnoses of Dementia, demia, Diabetes, Chronic III, Pain, and Sexual d contained an FCS dated s "admission" FCS. The d any additional FCS. This unable to perform bathing,				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B089087	B. WING		12/2	3/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
AUTUMN	HOME PLUS 2	TOPEKA,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
S5085	management; in need toileting, transfers, an incontinence, impaire impaired vision, impaire	edication and treatment I of physical assistance with d eating; with bladder d communication, falls, ired decision making, and nition impairments.  m Operator/Licensed	S5085			
S5155 SS=E	(a) The administrator plus shall ensure that or coordinates the procare services that me resident and are in accapacity screening aragreement.  This REQUIREMENT by: KAR 26-42-204(a)	or operator in each home a licensed nurse provides ovision of necessary health	S5155			

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  TOPICA, KS 68817  TOPICA, KS 68817  SUMMARY STATEMENT OF DEPICIENCIES  SUMMARY STATEMENT OF DEPICIENCIES  SUMMARY STATEMENT OF DEPICIENCIES  SUMMARY STATEMENT OF DEPICIENCIES  SOURCE (AGO) DEPICIENCY MUST SE PRESCRICE AN FIGURA  REGULATION OF CRESS (DEVINEYING INFORMATION)  SS1155  Continued From page 2  three Residents. The facility assessed all Residents with meal service. Based on observations, interviews, and reviews of record, for one of one sampled with recurrent coughing and choking episodes (#187), the Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each Resident.  Findings included:  - Review of record revealed #187 admitted to facility 0/10/1/14 with diagnoses of Dementia, Hypertension, Dyslipidemia, Diabetes, Chronic kidney disease Stage III, Pain, and Sexual behaviors.  The current functional capacity screen (FCS) of 11/05/13 assessed #187 unable to perform bathing, dressing, mobility, medication and treatment management, in need of physical assistance with ioteling, transfers, and eating; with bladder incommence, impaired communication, falls, impaired vision, impaired decision making, and with memory and cognition impairments.  The current negotiated service agreement (NSA) documented #187 with bathing assistance, dressing assistance, toleting, transfer, and mobility assistance; and medication/treatment management provided by facility staff. The current NSA of 10/10/14 documented #187 with "regular diet has trouble swallowing bread - coughs a lot."  Resident Care Notes of 5/05/14 described #187 with choking incident staff performed the		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING:  COMP		SURVEY PLETED			
AUTUMN HOME PLUS 2  TOPERA, KS 6617  TAG  SUMMARY STATEMENT OF DEFICIENCIES  FRACT DEFICIENCY MUST BE PRECEDED BY FULL FRED TAG.  SOUTH TOPERA TO A STAULD BE CONTINUED TO THE PROVIDERS PLAN OF CORRECTION CONTINUED TO THE PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED OF MEAN PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED OF MEAN PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED OF MEAN PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED OF MEAN PROVIDERS PLAN OF COMPLETE CONTINUED TO THE PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED OF MEAN PROVIDERS PLAN OF COMPLETE CONTINUED TO THE PROVIDERS PLAN OF CROSS-REFERENCED ON PARKWORM PROVIDERS PLAN OF CROSS-REFERENCED OF THE PROVIDERS PLAN OF CROSS-REFERENCED TO THE CROSS-PROVIDERS PLAN OF CROSS-REFERENCED TO THE CROSS-PROVIDERS PLAN OF CROSS-PROVI			B089087	B. WING		12	/23/2014
TOPEKA, KS 66617    (X4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF CORRECTION   CRACH CORRECTIVE ACTION SHOULD BE   CHOSS-MERER PLAN OF CHOSS-MERER PLAN OF CORRECTIVE ACTION SHOULD BE   CHOSS-MERER PLAN OF CORRECTIVE ACTION SHOULD BE   CHOSS-MERER PLAN OF CHOSS-ME	NAME OF P	ROVIDER OR SUPPLIER			, ZIP CODE		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  S5155  Continued From page 2  three Residents. The facility assessed all Residents with meal service. Based on observations, interviews, and reviews of record, for one of one sampled with recurrent coughing and choking episodes (#187), the Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each Resident.  Findings included:  - Review of record revealed #187 admitted to facility 01/01/14 with diagnoses of Dementia, Hyppertension, Dyslipidemia, Diabetes, Chronic kidney disease Stage III, Pain, and Sexual behaviors.  The current functional capacity screen (FCS) of 11/05/13 assessed #187 unable to perform bathing, dressing, mobility, medication and treatment management, in need of physical assistance with tolleting, transfers, and eating; with bladder incontinence, impaired communication, falls, impaired decision making, and with memory and cognition impairments.  The current negotiated service agreement (NSA) documented #187 with bathing assistance, dressing assistance, tolleting, transfer, and mobility assistance; and medication/freatment management provided by facility staff. The current NSA of 01/01/14 documented #187 with "regular diet has trouble swallowing bread-coughs a lot."  Resident Care Notes of 5/05/14 described #187	AUTUMN	HOME PLUS 2		_			
three Residents. The facility assessed all Residents with meal service. Based on observations, interviews, and reviews of record, for one of one sampled with recurrent coughing and choking episodes (#187), the Operator failed to ensure a Licensed nurse provided or coordinated the provision of necessary health care services that met the needs of each Resident.  Findings included:  - Review of record revealed #187 admitted to facility 01/01/14 with diagnoses of Dementia, Hypertension, Dyslipidemia, Diabetes, Chronic kidney disease Stage III, Pain, and Sexual behaviors.  The current functional capacity screen (FCS) of 11/05/13 assessed #187 unable to perform bathing, dressing, mobility, medication and treatment management; in need of physical assistance with tolleting, transfers, and eating; with bladder incontinence, impaired communication, falls, impaired vision, impaired decision making, and with memory and cognition impairments.  The current negotiated service agreement (NSA) documented #187 with bathing assistance, dressing assistance; and medication/treatment management provided by facility staff. The current NSA of 01/01/14 documented #187 with "regular diet has trouble swallowing bread - coughs a lot."  Resident Care Notes of 5/05/14 described #187	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
Heimlich maneuver when #187 consumed turkey	S5155	three Residents. The Residents with meal sobservations, intervie for one of one sample and choking episodes to ensure a Licensed coordinated the proviscare services that me Resident.  Findings included:  Review of record refacility 01/01/14 with of Hypertension, Dyslipickidney disease Stage behaviors.  The current functiona 11/05/13 assessed #1 bathing, dressing, motreatment manageme assistance with toileti with bladder incontine communication, falls, decision making, and impairments.  The current negotiate documented #187 with dressing assistance; a management provide current NSA of 01/01/1 "regular diet has trocoughs a lot."  Resident Care Notes with choking incident.	facility assessed all service. Based on ws, and reviews of record, ed with recurrent coughing is (#187), the Operator failed nurse provided or sion of necessary health it the needs of each  Evealed #187 admitted to diagnoses of Dementia, demia, Diabetes, Chronic III, Pain, and Sexual  I capacity screen (FCS) of 187 unable to perform bility, medication and nt; in need of physical ng, transfers, and eating; ence, impaired with memory and cognition  Id service agreement (NSA) high bathing assistance, toileting, transfer, and nd medication/treatment diby facility staff. The 14 documented #187 with uble swallowing bread - 16 5/05/14 described #187 staff performed the	S5155			

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	B089087	B. WING		12/	23/2014
NAME OF PROVIDER OR SUPPLIER  AUTUMN HOME PLUS 2	720 NW	DDRESS, CITY, STATE WALNUT LANE A, KS 66617	, ZIP CODE		
PREFIX (EACH DEFICIENCY MU	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
and cheese sandwich in family "will monitor and diet if needed"  The Medical Record lacked physician contact regardin Heimlich, and lacked a physician to pureed. The N Service Plan lacked docu pureed foods and thicken record lacked a physician of thickened liquids.  By interview on 12/23/14 Operator/Licensed Practic stated I believe it is to be Operator/LPN #D confirm lacked a physician's order stated #187 on Hospice with thickener at that time (F 01/13/14 documented Ho thickener" along with box supplies on 01/13/14).  By observation on 12/23/"Food Thickener" on kitch By interview, Direct Care process for mixing thicker failed to match the can lat preparation.  By observation on 12/23/"Care staff #G prepared no cooked carrots, all carrot in a food processor food consistency. #187 with locuphing when eating the Operator/LPN #D respondedling #187 to slow down	ed documentation of any choking and any sician's order for food consistency from SA and Resident mentation of the use of ed liquids. The medical 's order for consistency at 9:45am, cal Nurse (LPN) #D nectar consistency ed the medical record of for thickened liquids when admitted, no desident Care Note of spice staff "left can of of gloves and other at 9:45am, can of the counter. Staff #D described the liquids description of the liquids desc	S5155			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		B089087	B. WING		12/23/2014
	ROVIDER OR SUPPLIER HOME PLUS 2	720 NW V	DDRESS, CITY, STAT VALNUT LANE KS 66617	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
S5155	By observation on 12. Care Staff #G added approximately 8 ounce a knife (label specifi Tablespoon with 4 ou or fork, no spoon) s occasional coughing a drinking the coffee.  By interview on 12/23 Staff #J stated I mix 1 (480cc) think it's support to pure bouillon try to get to do not have written di of food  By observation on 12. Care Staff #J mixed be and with lasagna, ser compartment plate with loud vocalization substance.  Review of Resident Cadditional coughing/ci 7/06/14, 8/14/14, 9/02 #D and Facility Regis no order obtained for for preparation of pure directions for thickened the NSA or to the Resconfirmed NSA not signal.	ughing (NSA and Resident nese interventions).  (23/14 at 12:18pm Direct one scoop (Tablespoon) to es of coffee and stirred with ically directed to mix one nees of liquid, stir with whisk erved to #187 #187 with and loud vocalizations when  (14 at 3:00pm Direct Care 1/2 scoops per Red cup oposed to be Honey e food I add water or milk or applesauce consistency rections to follow for puree  (23/14 at 4:10pm, Direct coullion with green beans yield to #187 in a #187 again coughed and s when eating this slurry like are Notes documented hoking episodes on 6/13/14, 2/14, and 11/04/14.  (14 at 3:00pm Operator/LPN tered Nurse #F confirmed pureed diet, no directions eed items, no order or ad liquids nothing added to sident Service Plan gned by Resident or titve, and current Hospice	S5155		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		B089087	B. WING		12/2	3/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
AUTUMN	HOME PLUS 2	720 NW W TOPEKA,	ALNUT LANE KS 66617			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
S5155	Continued From page	÷ 5	S5155			
	provision of necessar met the needs of #18	o provide and coordinate the y health care services that 7 in regard to coughing and d the use of pureed foods				
S5171 SS=E	26-42-204 (i) Health (Practice	Care Services Standards of	S5171			
		vices shall be provided to staff in accordance with of practice.				
	This REQUIREMENT by: KAR 26-42-204(i)	is not met as evidenced				
	three Residents. Base interviews, and review sampled (#187), the C health care services of clarification, order imp negotiated service ag service plan documer	vs of record, for one of three Dperator failed to ensure of physician order blementation, and reement and Resident of tation, provided to d staff in accordance with				
	Findings included:					
	facility 01/01/14 with	evealed #187 admitted to diagnoses of Dementia, demia, Diabetes, Chronic III, Pain, and Sexual				
		I capacity screen (FCS) of I87 unable to perform				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B089087	B. WING		12/23/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE, ZIP CODE	
AUTUMN	HOME PLUS 2	TOPEKA,	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
S5171	with bladder incontine communication, falls, decision making, and impairments.  The current negotiate of 01/01/14 document has trouble swallowin current NSA documer assistance, dressing a transfer, and mobility medication/treatment facility staff.  By observation on 12/15 "Food Thickener" on 13/15 "Food Thickener" on 14/15 "Food	bility, medication and nt; in need of physical ng, transfers, and eating; ence, impaired impaired vision, impaired with memory and cognition  d service agreement (NSA) ted #187 with "regular diet g bread - coughs a lot." The nted #187 with bathing assistance, toileting, assistance; and management provided by  (23/14 at 9:45am, can of kitchen counter. are Staff #D confirmed only ener #187 #D stated I add red coffee mug with lid it is ters)  eview, can label directed addition of one Tablespoon each "4 ounces (120cc) of in to each 4 ounces of juice, are Staff #D acknowledged of followed for thickening of istency.	S5171	DEFICIENC!)	
	Operator/Licensed Pr stated I believe it is to Operator/LPN #D con	actical Nurse (LPN) #D be nectar consistency firmed the medical record order for thickened liquids ce when admitted, no			

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B089087	B. WING	<del></del>	12/23/2014
	ROVIDER OR SUPPLIER	720 NW V	DDRESS, CITY, STAT WALNUT LANE , KS 66617	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
S5171	staff "left can of thicked gloves and other support of the support	care Notes revealed Hospice ener" along with box of olies on 01/13/14.  Int Service Plan lacked use of thickened liquids, and lacked a physician's order exend liquids.  In Service Plan lacked use of thickened liquids, and lacked a physician's order exend liquids.  In Staff performed the other without the many the man	S5171		

Kansas Department on Aging
STATEMENT OF DEFICIENCIES

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
	_	B089087	B. WING		12/2	3/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
AUTUMN	HOME PLUS 2	720 NW WA TOPEKA, K	ALNUT LANE			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N I	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
S5171	1 Continued From page 8		S5171			
	Staff #J stated I mix 1 (480cc) think it's surconsistency to pure bouillon try to get to do not have written di of food  By interview on 12/23 #D and Facility Regis no order obtained for for preparation of pure The Operator failed to services of physician implementation, and ragreement and Resid documentation, providin accordance with ac practice.	the food I add water or milk or applesauce consistency irrections to follow for puree 3/14 at 3:00pm Operator/LPN stered Nurse #F confirmed pureed diet, no directions eed items.  To ensure health care a order clarification, order negotiated service	S5300			
SS=F	Medications  (d) Home administration medications. If a home administration of a result administrator or operated medications and biologications an	ion of resident 's ne is responsible for the sident 's medications, the ator shall ensure that all ogicals are administered to dance with a medical care der, professional standards manufacturer 's he administrator or operator of the following are met: reses and medication aides manage medications for responsibility.				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
		B089087	B. WING		12/23/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
AUTUMN	HOME PLUS 2	720 NW W. TOPEKA, I	ALNUT LANE KS 66617		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
S5300	Continued From page	9	S5300		
	medication through th	e parenteral route.			
	This REQUIREMENT by: KAR 26-42-205(d)	is not met as evidenced			
	three Residents. The Residents with facility Based on reviews of I three of three sample the Operator failed to biologicals administer accordance with writte	managed medications. records and interviews, for d (#189, #187, and #185), ensure all medications and red to Residents in en medical care provider ance with professional			
	Findings included:				
	facility 9/23/14 with di Alzheimer's, Hyperter issues, Arterioscleroti Depression. The current functiona 8/27/14 assessed #18 medication and treath The negotiated service 9/23/14 documented dispense medications Comparison of the De	nent management. ee agreement (NSA) of facility staff to set up and s. ecember 2014 MAR ation record) with written			
	MAR contained order (MOM) 30cc (cubic co	entimeters) po (by mouth)			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		B089087	B. WING		12/23/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
AUTUMN	HOME PLUS 2		WALNUT LANE , KS 66617		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
\$5300	order for this medicati MAR documented ad medication on 11/22/2 On 12/23/14 at 1:24pp Practical Nurse (LPN) signed order in the chipile at the office"  The Operator failed to biologicals administer with written medical coaccordance with professor practice.  - Review of record reviacility 01/01/14 with office Hypertension, Dyslipikidney disease Stage behaviors. The current functiona 11/05/13 assessed #1 medication and treatmedications. Comparison of the December of 9/23/14 documented medications of the December of the	icked a signed physician's ion. The November 2014 ministration of the 14 at 0800.  Im Operator/Licensed of #D stated I don't have a part it may be in the "to file of ensure all medications and red to #189 in accordance provider orders and in ressional standards of the ensure all medications and red to #189 in accordance provider orders and in ressional standards of the ensure are provider orders and in ressional standards of the ensure all medications and in ressional standards of the ensure are provider orders and in ressional standards of the ensure are provider orders and in ressional standards of the ensure are provider orders of Dementia, demia, Diabetes, Chronic III, Pain, and Sexual III, Pain, and	\$5300		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:				E SURVEY PLETED		
			B. WING			
		B089087	B. WING		12	2/23/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AUTUMN	HOME PLUS 2	720 NW	WALNUT LANE			
AOTOMIN	1101112 1 200 2	TOPEKA	A, KS 66617			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
\$5300	Acetaminophen 325m as needed for pain Exelon 9.5mg/24 hou remove old patch before On 12/23/14 at 2:20p Practical Nurse (LPN) #F stated we don't hat chart no signed ord January 2014 Hosp from when he/she was changed physician, but from that time on  The Operator failed to biologicals administer	ng two tabs every 4-6 hours  rs one patch on daily, ore placing the new one  m, Operator/Licensed ) #D and Registered Nurse ave signed orders in the	\$5300			
	accordance with profer practice.  - Review of record refacility 11/19/14 with of Agitation, Sundowning Care intolerance. The current functiona 11/17/14 assessed #1 medication and treatm The negotiated service documented facility of medications. Comparison of the Definedication administrictly physician's orders review MAR contained order two tabs po (by mouth needed); written physician with physician phy	essional standards of  evealed #185 admitted to diagnoses of Dementia, g, Self endangerment, and I capacity screen of 185 unable to perform ment management. ee agreement of 11/19/14 taff to administer ecember 2014 MAR ation record) with written realed discrepancies:  for Acetaminophen 325mg n) every 6 hours PRN (as ician's order of 11/19/14 the or temperature above				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
		B089087	B. WING		12/23/2014
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  720 NW WALNUT LANE  TOPEKA, KS 66617					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
\$5300	directed Olonzapine 5 HS (bedtime) as need (administered 12/10/1 MAR contained order (cubic centimeters) po (constipation); medical MAR contained order suppository one rectainedical record lacked On 12/23/14 at 12:39 Practical Nurse (LPN) usually 2000 On 12 no signed orders for to biologicals administer	for Olonzapine 5mg tablet as needed for sician's order of 11/19/14 5mg tablet 1/2 tablet every ded for agitation 4 at 1450) Milk of Magnesia 30cc o (by mouth) daily al record lacked this order for Bisacodyl Dulcolax lly 10mg (constipation); I this order  pm, Operator/Licensed o #D stated bed time is /23/14 at 12:42pm #D stated hese in medical record.  o ensure all medications and ded to #185 in accordance are provider orders and in	\$5300		